Documentation – 40.010

PROCEDURE:

A. A patient care report shall be generated for each identified patient and shall be completed on an approved State EMS patient care form.

B. Documentation should follow DACHARTE format
   - Dispatch: Nature and location of call provided by dispatch. Code 1 or Code 3 response.
   - Arrival: Brief scene size up. Any factors that may complicate or impede care.
   - Chief complaint: Patient or family member report of current problem - brief.
   - History: Pertinent complaint-based PMH and HPI. Utilize mnemonics such as SAMPLE, OPQRST, or AEIOUTIPS for structure.
   - Assessment: Findings and interpretation of vital signs and pertinent complaint-based findings on primary and secondary survey. Interpretation of other diagnostic results such as EKG.
   - Rx (Treatment): Any treatment and/or intervention provided on scene as well as rationale and patient response to intervention.
   - Transport: Destination and mode (Code 1 or 3). To whom the patient was released.
   - Exceptions: Any notable complicating circumstances. Documentation for patient refusal.

C.

D. Documentation shall include, at least:
   1. The patient's presenting problem.
   2. Vital signs with times.
   3. History and physical findings as directed in by individual protocols.
   4. Treatment(s) provided, and time(s).
   5. If monitored, ECG strip and interpretation.
   6. If an advanced airway is placed, a difficult airway assessment must be performed and communicated with rest of the provider team prior to performing the airway procedure. This difficult airway assessment should be documented in detail in PCR.
   7. Any change in the condition of patient.
   8. OLMC contact:
      a. Include physician name
      b. Time of contact
      c. Orders received from physician

E. A copy of the Prehospital Care Report must be left or sent to the receiving hospital whenever a patient is transported per ORS 333-250-0044.

F. If a patient refuses treatment and/or transport, refer to Refusal and Informed consent procedure.